

South Dakota Health Care Solutions Coalition

Meeting Notes 11/04/2015

Attendees: Sen. Corey Brown, Brenda Tidball-Zeltinger, Jerilyn Church, Kim Malsam-Rysdon, Dr. Mary Carpenter, Sunny Colombe, Ron Cornelius, Rep. Justin Cronin, Jason Dilges, Terry Dosch, Rep. Don Hagggar, Richard Huff, Monica Huber, Sen. Deb Soholt, Lynne Valenti, Sonia Weston, Sara DeCoteau, Sen. Bernie Hunhoff, Mike Diedrich, Jennifer Stalley, Janet Jessup, Sen. Deb Peters, Sen. Spencer Hawley, Gil Johnson, Evelyn Espinosa, Charlene Red Thunder, Deb Fischer-Clemens

Welcome and Introductions

An opening prayer was offered by Floyd DeCoteau.

Review of Previous Meeting Minutes

The last meeting focused on the basics of Medicaid eligibility, including an overview of the South Dakota Medicaid program, income levels, explanation of Federal/State financing of the program, and how Medicaid is funded for Native Americans that receive services through IHS and Tribal 638 clinics. There was also an in-depth discussion on how services are financed for Native Americans who receive services outside of the IHS/638 setting and how the State currently supports that care through the regular state (about 50%) FMAP funding. The presentation is on the Health Care Solutions website at

<http://boardsandcommissions.sd.gov/bcuploads/Coalition%20Discussion%202010-21-15.pdf>

Attendees were directed to the previous meeting minutes for additional information and discussion points from previous meetings. Questions and answers are also included in the minutes.

http://boardsandcommissions.sd.gov/bcuploads/SD%20%20Health%20Care%20Solutions%20Coalition%20meeting%20minutes%202010-21-2015_DRAFT.pdf

There are three subcommittees that are meeting concurrently with this group: The Access Subcommittee, The New Services Subcommittee, and the Behavioral Health Subcommittee. Subcommittee minutes and meeting materials can be found on the Health Care Solutions Website archive at

<http://boardsandcommissions.sd.gov/Template.aspx?id=145>

Subcommittee Reports

Increasing Access to Services Provided through Indian Health Services Subcommittee:

The subcommittee considered ideas from non-Indian health providers on ways to increase access to services through IHS/Tribal programs. The subcommittee prioritized three areas: : e-emergency services using Tele-health to support and expand services at IHS emergency departments; increasing access to OB/GYN services including using Tele-health for additional supports; and, general surgery services through bringing providers to IHS/Tribal facilities. Providers have developed specific strategies around these concepts and the subcommittee will continue to refine those concepts to develop action steps that increase access.

New Services Subcommittee:

This subcommittee met this morning (11/4) for the first time after an organizing call last week. The focus of this group will to further explore two specific services: Community Health Representative services (CHRs) and Medication Therapy Management (MTM). Evelyn Espinosa, Bernie Long and Sonia Weston shared information about the CHR programs in each of their health programs and sites. Among the three CHR programs discussed, a significant portion of services are transportation but other service needs such as wound care, medication management, and other services were identified as needed services CHRs could provide. Capt. John Schuchardt, IHS Great Plains Area Chief Pharmacist provided information regarding the IHS pharmacy program and MTM. The subcommittee will be looking at both of these services in context of the Health Homes program, as well as generally within Medicaid to identify opportunities we can act on leveraging current infrastructure. The group discussed how to better coordinate across all the systems to support patients.

The Behavioral Health Subcommittee:

This subcommittee will meet for the first time tomorrow (Thursday 11/5) morning. The subcommittee will first focus on education regarding the current state and tribal behavioral health programs. The subcommittee will focus on opportunities there are today that could be leveraged, as well as discussing new opportunities to increase access to services in the longer term.

Update on Conversation with CMS

The Centers for Medicare & Medicaid Services (CMS) released its white paper (10/27) looking for comments on proposed policy changes regarding the circumstances in which 100 percent federal funding would be available for services furnished to Medicaid-eligible American Indian and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS) or Tribes. The intent of this policy change, which would apply to all states, would be to improve access to care for AI/AN Medicaid beneficiaries. CMS' paper describes the policy options under consideration and seeks feedback from states, Tribes, and other stakeholders. The paper can be found on the Medicaid.gov website at:

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/downloads/tribal-white-paper.pdf>

CMS has given a three-week window to comment and specifically asked South Dakota to provide comment based on the work the State has been doing with CMS related to these issues.

Brenda Tidball-Zeltinger gave a brief overview of the current structure for how South Dakota Medicaid can claim 100% FMAP today.

1. Medicaid eligible + AI/AN
2. Must be a current "facility service" – an area of change
3. Must be furnished "in" an IHS/Tribal facility
4. Must continue to retain responsibility for provision of the service and billed by IHS/Tribal facility to the Medicaid program

She walked the group through the key points of the paper that modify these requirements (p3). The goal is expanded capacity and access at IHS/Tribal facilities. There are no changes to the first condition of participant eligibility.

The white paper redefines the “received through” concept. The new rule would allow any service covered by the State Medicaid plan that meet certain conditions to potentially be eligible for 100% FFP. Waiver services would not be eligible, and administrative costs would not be eligible. Other services such as NEMT and emergency transportation would be eligible for 100% FMAP (if not counted as administrative costs).

South Dakota Medicaid reimburses NEMT as an administrative service today; so this would need to change in the state plan for the State to get 100% FMAP. Transportation currently is a relatively small percentage of the total Medicaid budget; but it is worth looking at how to leverage as much federal funding as possible. The administrative FMAP is always 50%, the services FMAP changes each year and is approximately 50%.

The bigger changes are with the third and fourth conditions. CMS is considering expanding the meaning of contractual service and expanding the meaning of the facility services. This would allow IHS/Tribal facilities to deliver services through contracts with non-IHS/Tribal providers and the State could get the 100% FMAP for those services. CMS is expanding the scope of services that can be provided outside the “four walls” of an IHS/Tribal facility. CMS is allowing more flexibility for both IHS/Tribal providers and state Medicaid programs. The language around retaining “control” of the patient also expands the expectations of IHS to be more involved in the care coordination of the patients.

Ron Cornelius noted that this would have huge implications for IHS to be able to track and manage the care plans. One way to address this this would be through IHS quality oversight in these contracts. This is an issue especially for individuals who have gotten care outside of IHS for many years. Sen. Soholt said there are some ways to help ensure care coordination across IHS/Tribal providers and that there needs to be scrutiny of the contracts so there is a seamless handoff for care to continue for patients.

Jerilyn Church noted that the original intent probably was that, but the wording is somewhat complicated. CMS also has to be mindful of the Tribal facilities that maintain their own medical records, and that may explain why some of this is written the way it is. It has to be broad enough to accommodate all the different Tribes across the US and IHS, all of which are designed a bit differently. We want to identify the possible unintended consequences and how we can best make this work for South Dakota.

Richard Huff/Jerilyn Church –raised the need to include the Urban Health providers, and how they can be better connected to both IHS and Tribal members.

The fourth condition covers the mechanism by which IHS/Tribal facilities bill, and would allow non-IHS/Tribal providers to bill *either* IHS/Tribal facility *or* directly to Medicaid. Currently non-IHS/Providers must bill IHS/Tribal program. IHS determines the billing mechanisms. This is a positive change that would eliminate current barriers relative to billing and payment.

Ron Cornelius noted that this would be helpful for Great Plains IHS because they would not have to increase administrative staffing to do billing. Kim also said this would support providers being reimbursed at the same rate for services they are today through Medicaid. Managing service delivery within the IHS encounter rate for services that today a provider receives the Medicaid fee for service payment structure would be problematic.

The last part of the paper discusses what would be allowed in FFS vs. Managed Care environments. All services are paid at the outpatient encounter rate or at the inpatient daily per diem rate. This would change in that some encounters would be paid at the State’s FFS rates instead of the encounter rates. This has unintended consequences as providers could be paid vastly different rates for the same services they provide today and in some cases it could impact IHS revenue. The rate would go up or down for a variety of services. Tribal health

programs may not support that. It has a lot of administrative complexities for IHS, providers, and Medicaid to manage.

South Dakota had a call with CMS last Friday and discussed some of these issues with them at that time. We learned that CMS expects states to do these changes via State Plan Amendment vs. waiver, which is a positive. CMS was provided some specific examples to help clarify some key aspects of the white paper that will determine what flexibility the state will achieve with these changes.

1. What does it mean for care to be arranged and overseen by IHS? Care coordination should be broader to focus on population health as opposed to more structured and patient specific care coordination. As an example, an individual living in Sioux Falls eligible for Medicaid and IHS accesses care through Urban Indian Health. Geographically, the Wagner IHS facility is over 100 miles away. The policy should not disrupt the care received by the person now. Ron noted that CMS just wants to make sure that the contracts are being managed and the providers are delivering care appropriately. Would want to include what medical management should be in those contracts.
2. The definition of facility-based services was the second area raised with CMS. CMS shared information that sounded as though they wanted to limit the services eligible for 100% FMAP by limiting the ability for IHS to contract for services provided under that type of facility (i.e. clinics could only contract for other clinic based services). South Dakota outlined how primary care, specialty care, and hospital based services work and also noted examples for very specialized services IHS wouldn't provide the services (NICU or other specialties).
3. Reimbursement rates and unintended consequences of over- or under-utilization of services based on rates.

Ron Cornelius shared that the contractual issues are a big deal, depending on what the requirements are. Who owns the medical record is a problem and a feasibility issue if IHS isn't providing the care. IHS has some feasible solutions to ensure that IHS can still have clear oversight through contractual relationships in the same way that referrals occur today. If you are assigning care to the contractor, then IHS needs to ensure that the contractor is providing appropriate care, but would need to address how to keep the medical record updated when individuals access care without referral or coordination from IHS for whatever reason. When a patient is discharged today the facility will send a summary report to their IHS or Tribal provider. The new rule should work the same way. There could be improvements in the exchange of information through the state's Health Information Exchange, EMRs or even paper records.

Deb Fisher Clemens noted that many of the health systems and providers use the State's HIE to share patient information. IHS has contacted the HIE recently about doing the same. That is one way that this could be done in South Dakota.

In the last meeting the contract discussion raised questions about services provided by non-IHS providers in IHS facilities. Ron Cornelius outlined that IHS does some of this today, with limited success. It does take a long time to do contracts and in addition to the contract challenges, certain services require specialized equipment and oftentimes outside providers are unwilling to conduct certain procedures due to challenges with required equipment, etc.

Kim Malsam-Rysdon suggested that the white paper comments include a contracting approach that is fundamentally different than it is today.

The CMS white paper contemplates contracting for provision of care by other providers – Ron indicated that would be much simpler and suggested that MOUs, or other more streamlined contracting approaches could simplify the contracting process and we should suggest that to CMS.

Jerilyn Church noted that IHS has a process that they will need to review to ensure the policy around the type of contract these services will fall under.

The group discussed that while CMS cannot mandate to IHS how to do things, HHS has that authority. The Medicaid State Plan could suggest a contract structure that would outline a simpler way for Great Plains IHS to do something broader to encompass the whole region as opposed to service unit level agreements. Kathaleen Bad Moccasin shared that IHS can do multiple award contracts for services and any approach should consider all AI/AN's get access to the expanded services not just those eligible for Purchased and Referred Care (PRC).

Kim Malsam-Rysdon said we need to think in terms of what we would need for South Dakota to leverage funding to expand Medicaid. Ron Cornelius noted that Medicaid expansion in South Dakota can improve the IHS budget similar to the effect that North Dakota experienced. Expansion will help our patients see direct benefit. One CHSDA for SD/ND, would be the next step. In order to expand we have to be able to cover the costs. The approaches will also need to consider Urban Indian Health (UIH) clinics and how they fit into this to ensure that individuals that live outside IHS service areas can access care. Kim Malsam-Rysdon suggested IHS help the coalition learn more about the IHS contract process to better understand it and the different options we might have for moving forward on these ideas. HMA will help facilitate gathering this information and develop an outline to share with the coalition. Jason Dilges suggested that we frame these ideas as recommendations on the contracting approaches for the white paper.

Kim Malsam-Rysdon concurred this is the best approach and suggested help from Ron would be necessary to do that. We also need to continue to educate CMS relative to how care is delivered and how these processes work so we have maximum flexibility and are ready to go if we move forward. Kim suggested that coalition members send comments or questions to Kelsey Smith by November 6. Examples are really useful and being specific gives CMS better information to work from. Comments will be compiled and shared with the coalition. It will be most beneficial to frame comments relative to how South Dakota thinks this should work.

Ron noted that the CHSDA conversation does matter in the white paper conversation and impacts IHS and the Tribes, but we need money to implement it and expansion could actually help with that funding. Jerilyn said tribes in the Great Plains area have put this on the agenda the last three years and are less concerned about the money than IHS – they just want the ability for Tribal members to get care.

Kim noted that support from stakeholders would be positive but CMS suggested a large volume of letters won't add as much value. The approach will be to represent the comments to CMS as coming from the Coalition and the coalition members concurred with that approach.

IHS and Tribal leaders are meeting next week and can probably get support with a revised resolution from the Tribal Chairmen's Health Board. Janet Jessup will help with this.

Care Coordination

The white paper gives us a bit more information about this, but we still need to discuss how we can better understand what happens today and how we can support improvements that increase access. Deb Fischer-Clemens presented success stories through Avera relative to how good care coordination positively impacts

patient health care and controls costs. An example included an individual part of the Medicaid Health Home program seen multiple times in ER. Once in a Health Home the care coordinator and team identified issues with food, housing, etc. that he was not telling anyone. The social worker and nurse discovered these issues and began working with him to connect to services and supports he needed. Within 4-6 weeks his health had improved dramatically, his demeanor changed and even his family relationships improved.

On a broader scale, 673 patients over three months saw significant improvement in health and care: 18.2% decrease in ED, 12.4% inpatient admission decrease, PCP increase 7.4%, other treatment visits 29%. A 52% improvement in mammograms, 31% in pap, 37% colorectal, diabetes composite 5%, hypertension 16%, obese pts. 8% lost at least 10% of weight.

IHS is involved in Health Homes, and that system's public health nurses are very heavily engaged in that. We might look at those services that could be expanded and continue to explore behavioral health services.

Health Homes Program

Lynne Valenti presented an overview of the South Dakota Medicaid Health Homes program.

Presentation can be found at:

<http://boardsandcommissions.sd.gov/bcuploads/HH%20Care%20Coordination%2011042015.pdf>

The Health Homes initiative includes six core services including Comprehensive Care Management and Care Coordination program that provides enhanced health care services to individuals with high-cost chronic conditions or serious mental illness to improve health outcomes and reduce costs related to uncoordinated care.

The Health Homes initiative is open to Medicaid recipients who have:

- Two or more chronic conditions, or
- One Chronic condition and at risk for another
 - Chronic conditions include: Mental Illness, substance abuse, asthma, COPD, diabetes, heart disease, hypertension, obesity, musculoskeletal, and neck and back disorders
 - At risk conditions include: pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and use of multiple medications (6+ classes of drugs)
 - One severe mental illness or emotional disturbance

The program pays a Per Member per Month (PMPM) fee for HH services.

Enrollees are classified by tier based on level of needs; Tiers 1 – 4 (4 highest need/cost)

- Tier 1 enrollees, lowest need, have to opt in;
- Tier 2 – 4 have to opt-out.

Case studies on slides are actual Medicaid HH enrollees.

Total program enrollment 5,884, 34% served by his. The program started in August 2013, 75% of those eligible in a Home Homes service area participate in the Health Homes program. Leveraging current IHS health homes and expanding the health home model will be important considerations as we consider ways to improve access to care.

There are 113 Health Homes in 121 locations (25 FQHCs, 11 IHS, CMHCs 11, private 66). Providers are actively engaged and preliminary results suggest high patient satisfaction. The program is working to analyze data on specific patient outcomes.

Kim Malsam-Rysdon noted that we need to ensure that enrollees have effective care coordination that is not disrupted. We don't want funding changes to disrupt the things that are working, such as HHs. Jerilyn Church asked if any of the tribal 638 programs participate in the HHs program; it was confirmed that these programs do not currently participate.

Kim Malsam-Rysdon explained the criteria to become a Health Home, discussed the application process and the care coordination criteria that a provider must meet to participate in the initiative. Jerilyn Church raised the issue of how Community Health Representatives (CHRs) would be integrated into the HHs. Since 35% of current HH enrollees are through IHS, this presents real opportunities to leverage the CHRs and the existing relationships that patients have with the CHRs. Kim noted that health promotion and other community referral services that are part of the HH make sense to utilize CHR's to provide. IHS could pay for that service as part of the rate they receive and Ron concurred this made sense.

Great Plains Tribal Chairmen's Health Board Initiative with CareSpan

Jerilyn Church said the Great Plains Tribal Chairmen's Health Board has entered into a relationship with CareSpan, a technology platform and helps with provider recruitment and access to services. This will be covered more in the Access to Care Subcommittee.

Next Steps:

- Comments on white paper to Kelsey by Friday (11/13)
- Draft questions due back to the Coalition group prior to submission to CMS (If don't hear from you, assume your support!)
- IHS contracting process overview
Updated projections on expansion costs

Next Meeting

Wednesday, November 18, 1 – 3 p.m., Ramkota Gallery B